PRINTED: 09/28/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COM	MPLETED
		15G496	B. WING		08/3	31/2012
NAME OF I	DROLUBER OR GURRI IEI			ADDRESS, CITY, STATE, ZII	P CODE	
NAME OF I	PROVIDER OR SUPPLIE	К	2333 W	VESTDALE CT		
BONA VI	ISTA PROGRAMS	INC	KOKO	MO, IN 46902		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX	·	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	IE APPROPRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
W0000						
	This saisit sass for		11/0000			
	This visit was for an annual fundamental		W0000			
	recertification a	nd state licensure survey.				
	Datas a C ii ii	. A				
	1	: August 29, 30, and 31,				
	2012					
	Facility Number					
	Provider Number	er: 15G496				
	Aims Number:	100245040				
	Surveyor: Kath	y Craig, Medical Surveyor				
	III					
	These deficience	ies also reflect state				
	findings under 4					
	inidings under 4					
	Quality Pavious	was completed on 9/7/12				
		•				
	by 11m Snebel,	Medical Surveyor III.				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE : COMPL 08/31/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE STDALE CT MO, IN 46902	1	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEPICIENCY)	TE	(X5) COMPLETION DATE
W0104	483.410(a)(1) GOVERNING BC The governing body policy, budget, and the facility. Based on observing governing body direction over the 2 of 4 sampled considerable bedroom carpet stains.  Findings include Observations we home on 8/30/12 AM. In client #1 was a light tan care foot long dark stabed. There were stains, 1/8 inch in close to the door dining room.  Client #1 was interested to the door dining room.  Client #1 was interested to the door dining room.  Interview on 8/3 resident manager resident manager been having accimedication changer medication changer to the source of the considerable was a serious discourse of the consider	dy must exercise general ad operating direction over ation and interview, the failed to exercise general e facility by not ensuring lients' (client #1 and #3) was kept clean and free of from 6:32 AM to 8:00 and #3's bedroom, their arpet. The carpet had one ain in front of client #3's twenty-five circular and diameter, on the carpet that lead out to the ferviewed on 8/30/12 at lent #1 stated the foot "poop" stain.  10/12 at 6:56 AM with the rewas conducted. The reindicated client #3 had dents after he had	WO	104	The carpets will be cleaned or 9/21/12. The staff were retrain on their cleaning duties and reporting needed repairs/maintenance to management in a timely mann. The House Manager is responsible for scheduling rou household maintenance (ie. carpet cleaning, insect spraying etc). The Social Service Coordinator will complete inspections of the houses on a quarterly basis looking for area that need improvements/repair/maintenate. The corrective actions were completed and in place on September21, 2012.	ned ner. ng, a as	09/21/2012

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	of correction identification number:  15G496	A. BUILDING  B. WING	00	COMPL 08/31/	ETED		
	PROVIDER OR SUPPLIER STA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE  2333 WESTDALE CT  KOKOMO, IN 46902					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE		
	QDDP #1 and QDDP #2 (Qualified Developmental Disabilities Professional) was conducted. QDDP #1 indicated the carpet was cleaned quarterly and they were waiting until the painting was done in the home. QDDP #2, who was in training, indicated she didn't know how often but indicated it should be due within the next month.  9-3-1(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/31/2012		
		15G496	A. BUILDING B. WING				
			B. WIN		ADDRESS CITY STATE ZIR CODE	1	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE /ESTDALE CT		
BONA VI	ISTA PROGRAMS I	NC	KOKOMO, IN 46902				
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0149	The facility must written policies ar mistreatment, neg Based on record facility failed to abuse/neglect by the administrator incidents at the g client to client pl Findings include  Review on 8/29/BDDS incident r following incide "was listening to mad and said [cl [Client #7] pinch right upper arm a lower back on th The report indicate when the to the administrative responsibility of the possesses knowledges and mistread to the responsibility possesses knowledges and record facility mistread to the responsibility possesses knowledges and record facility mistread to the responsibility possesses knowledges and record facility mistread to the responsibility possesses knowledges and record facility facility mistread to the responsibility possesses knowledges and record facility	r not providing evidence r was notified in 1 of 4 group home regarding hysical aggression.  12 at 2:10 PM of the reports included the nt: On 5/5/12, client #7 his CD player. He got ient #3] was being rude. ned [client #3] on the and smacked him on the way to his bedroom." hted client #3 "was ries. He had a quarter is right upper arm." There during record review to is incident was reported	W0	149	The Neglect, Battery and Exploitation of Individuals pol was reviewed with the QDDP direct care staff on 09/19/12. QDDP was trained on the "Investigation of Injury" form to used for allegations, injuries a other investigatory purposes. The investigation form include place that states "administration notified". The QDDP understands that incident reports to the administrator. BDDS reports shared agency wide to ensure proper communication. The corrective actions were completed and in place on September 21, 2012.	and The o be nd es a or orts are	09/21/2012

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  15G496	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 08/31/2012
	PROVIDER OR SUPPLIER STA PROGRAMS INC	2333 W	ADDRESS, CITY, STATE, ZIP CODE ESTDALE CT MO, IN 46902	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
	or psychological abuse to report it immediately, verbally and in writing, to the President or if the President is unavailable, the Senior Vice President"			
	Review on 8/30/12 at 1:10 PM of the Incident & Illness reports (I & I) was conducted. There was no I & I to correspond with the BDDS report mentioned above to indicate when it was witnessed or reported to the administrator.			
	Interview on 8/30/12 at 1:10 PM with QDDP #1 (Qualified Developmental Disabilities Professional) was conducted. QDDP #1 indicated an allegation of abuse/neglect should be reported to the administrator within 24 hours if it is just a bruise and not abuse.			
	9-3-2(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		15G496	B. WIN			08/31/	2012
NAME OF B					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2333 W	/ESTDALE CT		
BONA VI	STA PROGRAMS I	NC		KOKOMO, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0153	483.420(d)(2)	ENT OF CLIENTS					
		ensure that all allegations					
	•	neglect or abuse, as well as					
	injuries of unknov	vn source, are reported					
		e administrator or to other					
	officials in accordance with State law						
	through establish	review and interview, the	$ _{W_0}$	152	Direct care staff was retrained on (		09/21/2012
			*** 0	133	9-19-12 that they are to notify		U7/21/2U12
	_	report to BDDS (Bureau			supervisor immediately when a		
	•	al Disabilities Services)			injury occurs during client to cl		
		idents at the group home			aggression. Staff will complete		
		to client physical			the accident form indicating th		
		cordance with State law,			location, size, etc of the injury. When a significant behavior		
	•	vide evidence the			occurs, staff completes a CBIF	₹	
	administrator had	d been notified.			form and routes to the QDDP		
	Findings include	:			VP Residential Services for review. The QDDP will investigate all injuries/incident and complete a BDDS report	8	
	Review on 8/29/	12 at 2:10 PM of the			within 24 hours. The QDDP w	rill	
	BDDS incident r	reports included the			notify the VP of Residential		
	following incide	nt: On 5/5/12, client #7			Services. The QDDP will		
	"was listening to	his CD player. He got			complete a thorough	II	
	mad and said [cl	ient #3] was being rude.			investigation. The "investigation form will be attached to the	)[1	
	_	ned [client #3] on the			accident/incident and/or the		
	_	and smacked him on the			BDDS report. Per state		
	•	e way to his bedroom."			guidelines and agency policy,		
		ated client #3 "was			abuse/neglect/exploitation and		
	•	ries. He had a quarter			client to client aggression is al reported to APS. BDDS reported		
	_	s right upper arm." This			are shared agency wide to ens		
		ted to BDDS on 5/7/12.			proper communication.	· -·· <del>-</del>	
					Families/Guardians are notified		
		idence during record			all BDDS reportable incidents.	All	
		e when this incident was			Direct Care Staff attend the		
	-	dministrator or why it			agency wide BDDS reportable guidelines training annually in		
	was not reported	to BDDS within 24			addition to their individual grou	ıp	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G496		(X2) MULTIP  A. BUILDING  B. WING		NSTRUCTION 00	(X3) DATE S COMPLI 08/31/	ETED	
	PROVIDER OR SUPPLIER		233	33 WI	DDRESS, CITY, STATE, ZIP CODE ESTDALE CT IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAG	hours of the inci- Review on 8/30/ Incident & Illnes conducted. Thei correspond with mentioned above witnessed or rep  Interview on 8/3 QDDP #1 (Qual- Disabilities Profi QDDP #1 indica physical aggress reported within 2 indicated it shou	dent.  12 at 1:10 PM of the se reports (I & I) was re was no I & I to the BDDS report et o indicate when it was corted to the administrator.  10/12 at 1:10 PM with ified Developmental ressional) was conducted. It dead a client to client ion incident was to be 24 hours. QDDP #1 ld be reported to the thin 24 hours if it is just a	IAC		home trainings. The Elder JusticeAct guidelines are post in the group home for staff to review. The corrective action were completed and in place of September21, 2012.	s	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G496	B. WIN			08/31/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ESTDALE CT		
BONA VI	STA PROGRAMS I	NC			MO, IN 46902		
					1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
W0227	483.440(c)(4) INDIVIDUAL PRO	CORAM PLAN					
	The individual program plan states the specific objectives necessary to meet the						
	client's needs, as	-					
		ssessment required by					
	paragraph (c)(3)						
	Based on record	review and interview, the	W0	227	Client #1 and Client #3 have		09/21/2012
	facility failed for	2 of 4 sampled clients			revised oral hygiene goals. Th		
	(clients #1 and #	3) by not including dental			QDDP will review the physicia	n	
	recommendation	is into their program plan			statements and communicate with the nurse after appointment		
	goals.				to ensure that we are following		
					Dr. orders. The Periodic Servi		
	Findings include				Review, which is completed		
	1 manigs merade.				quarterly by the Residential		
	D : 0/20/	10 (11 07 AM C 1			Coordinator, reviews goals to	see	
		12 at 11:05 AM of client			that they match all		
		conducted. Client #1's			recommendations. The corrective actions were		
		ed 3/13/12 indicated			completed and in place on		
	client #1 needed	to brush his lower			September 21, 2012.		
	anterior and uppe	er right molar "better."					
	Client #1's ISP (	Individual Support Plan)					
	,	uded a toothbrushing					
		include these specific					
	_ ~	s from the dentist.					
	1000mmendunon						
	Pavian on 8/20/	12 at 12:05 PM of client					
		conducted. Client #3's					
		ed 5/24/12 indicated					
		eavy deposit" and he					
	needed to brush	gums and teeth two times					
	daily and floss or	ne time daily "if					
	possible." Client	t #3's ISP dated 6/6/12					
		brushing goal but did not					
	include the speci						
	-	of flossing his teeth one					
	Tecommendation	or mossing ms teem one					

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OF CORRECTION	IDENTIFICATION NUMBER:  15G496	A. BUILDING B. WING	00	COMI	PLETED 1/2012
PROVIDER OR SUPPLIER		2333 W	ADDRESS, CITY, STATE, ZIP VESTDALE CT MO, IN 46902	CODE	
STA PROGRAMS  SUMMARY S  (EACH DEFICIEN  REGULATORY OR  time daily.  Interview on 81/3  QDDP #1 and Q  They both indica	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)  30/12 at 1:20 PM with DDDP #2 was conducted.			SHOULD BE	(X5) COMPLETION DATE

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		15G496	B. WIN			08/31/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	<u>t</u>		2333 W	/ESTDALE CT		
	STA PROGRAMS I	NC		KOKON	MO, IN 46902		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG W0454		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DAT	.E
VVU454	483.470(I)(1) INFECTION CON	JTROI					
		provide a sanitary					
	environment to avoid sources and						
	transmission of in	fections.					
	Based on observ	ation and interview, the	W0	454	Staff were retrained on 9/19/12	09/21	/2012
	facility failed for	8 of 8 clients (clients #1,			on proper diabetic handling		
	#2, #3, #4, #5, #6	6, #7, and #8) who			procedures. If client does not initiate on her own, staff will di	rect	
	resided in the ho	me, by not ensuring			client #2 to throw her	601	
		way her bloodied test			contaminated insulin strip into	the	
	strip into a secured container, and not ensuring client #2 sanitized her hands				Sharp's container. Additionally		
					when Client #2 has finished		
		est strip to test her blood			checking her blood sugar, give	n	
	sugar, wiping off the blood with a paper				herself an insulin shot, or any other diabetic related activity,	she	
		giving herself insulin,			will immediately be directed to		
	before eating her	•			sanitize her hands with sanitiz	er	
	before eating her	oreakrast.			or wash them with soap. The		
	Eindings include			House Manager and Nurse will			
	Findings include	·			observe random med passes to ensure staff are following Med	°	
	01	1 . 1 . 1			Core A&B procedures in additi	on	
		ere conducted at the group			to proper health and safety		
		nts #1, #2, #3, #4, #5, #6,			guidelines. The corrective		
		ed, on 8/30/12 from 6:32			actions were completed and in		
		. At 7:10 AM, client #2			place on September 21, 2012.		
	_	and accucheck to test her					
	blood sugar. Aft	terwards, client #2 wiped					
	off the blood on	her finger with a paper					
	towel and threw	it and the bloody test					
	strip into the ope	en trash can, which clients					
	#1, #2, #3, #4, #3	5, #6, #7, and #8 had					
		med (medication) room.					
	•	erself a shot of 15 units					
	_	ulin for diabetes). After					
		ed of the needle in the					
	•	, she did not sanitize her					
	-	2 proceeded to go in the					
	nanus. Chent#4	proceeded to go iii tiic	1			1	

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	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPL	
THILD TEATLY	or condition	15G496		LDING		08/31/	
		.00.00	B. WIN		DDRESS, CITY, STATE, ZIP CODE	00.0	
NAME OF P	ROVIDER OR SUPPLIER				ESTDALE CT		
BONA VI	STA PROGRAMS I	NC			10, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		n two bowls and made		TAG	Dir Ichi. C. I		DATE
		poured cereal in the other.					
		t a measuring cup and					
	_	nt #2 sat down and ate					
		thout sanitizing her hands					
	_	blood sugar and giving					
	herself a shot of	IIISUIIII.					
	Interview on 8/3	0/12 at 1:05 PM with					
		DDP #2 (Qualified					
		Disabilities Professional)					
	•	QDDP #1 indicated					
		have thrown the bloody					
		sharps container. QDDP					
	•	lient #2 did not use an					
		e then should have used					
	· ·	washed her hands after					
		I sugar and giving herself					
	insulin.	sugar and giving nersen					
	msam.						
	9-3-7(a)						
	<i>y</i>						
	1						

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